ILLINOIS DEPARTMENT ON AGING

Authorization for Release of Information

I, _____, hereby authorize
(Name of Applicant/Client)

the Illinois Department on Aging to disclose the following information: _____

_____ ,

to _____ ,
(Person, Organization or Agency)

for the following purposes: _____

_____ .
(For example, a lawsuit or at the request of the Applicant/Client)

RIGHT TO REVOKE

I understand that I have the right to revoke this Authorization at any time by sending notification in **writing** to:

Privacy Officer
Office of General Counsel
Illinois Department on Aging
421 E. Capitol Avenue, #100
Springfield, Illinois 62701-1789

I understand that my revocation will have no effect on information that has been released under this Authorization prior to receipt of my intent to revoke such Authorization.

- I understand that this Authorization becomes effective on the date signed below and expires one year from the date of signature.
- I understand that the person receiving this confidential information may disclose such information which may affect the protection afforded by federal or state law.
- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my eligibility for benefits or my ability to obtain services.

Continue on back >

APPLICANT/CLIENT INFORMATION:

(Signature of Applicant/Client)	(Date)
(Print Applicant/Client Name)	(Date of Birth)
(Street Address)	(Social Security or I.D. Number)
(City, State and Zip Code)	(Phone)

LEGAL REPRESENTATIVE

If a Legal Representative executes this form, that individual is representing that he or she has authority to sign this form on the basis of:

(For example: Agent under Power of Attorney; Guardian; Executor of Estate; Health Care Surrogate)

The Legal Representative MUST attach all supporting legal documentation demonstrating their capacity as a Legal Representative when submitting this Authorization on behalf of the applicant/client, in order to obtain a copy of the requested records.

(Signature of Legal Representative)	(Date)
(Print Legal Representative Name)	(Phone)
(Street Address)	(City, State and Zip Code)

In order to obtain the requested information, you MUST mail this Authorization, along with any Legal documentation back to:	**Privacy Officer** **Office of General Counsel** **Illinois Department on Aging** **421 E. Capitol Avenue, #100** **Springfield, Illinois 62701-1789**

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